

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012394	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/28/2016
NAME OF PROVIDER OR SUPPLIER SUGAR GROVE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5865 SUGAR LN PLAINFIELD, IN 46168		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00188016.</p> <p>Complaint IN00188016 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 27, 28, 2016</p> <p>Facility number: 012394 Provider number: 012394 AIM number: N/A</p> <p>Census bed type: Residential: 103 Total: 103</p> <p>Census payor type: Other: 103 Total: 103</p> <p>Sample: 4</p> <p>Sugar Grove Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint IN00188016.</p> <p>QR was completed by 99993 on 01/28/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE